

GALANTAMINE PA SUMMARY

PREFERRED	Razadyne tablets, Razadyne extended-release capsules, Razadyne oral solution
NON-PREFERRED	Galantamine tablets, Galantamine ER capsules, Galantamine oral solution

LENGTH OF AUTHORIZATION: 1 Year

PA CRITERIA:

- ❖ Submit documentation of allergies, contraindications, drug-drug interactions, or show a history of intolerable side effects to the inactive ingredients in the same formulation of brand name Razadyne (preferred medication).

EXCEPTIONS:

- ❖ Exceptions to these conditions of coverage are considered through the prior authorization process.
- ❖ The Prior Authorization process may be initiated by calling **SXC Health Solutions at 1-866-525-5827**.

PA and APPEAL PROCESS:

- ❖ For online access to the PA process please go to www.ghp.georgia.gov, select the Provider Information tab, click on “view full text” in the Pharmacy Services box, click on “Prior Approval Process” in the list on the left.

QUANTITY LEVEL LIMITATIONS:

- ❖ For online access to the current Quantity Level Limit please go to www.ghp.georgia.gov, select Provider Information, click on “view full list” in the Medicaid Provider Manuals box then select Pharmacy Services from the list shown.